A co-production approach to exploring an integrated service model for people in Middlesbrough and Redcar & Cleveland

Final Report

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CONTENTS

Introduction

This research project, funded by the NIHR Clinical Research Network (CRN), North East and North Cumbria, is a collaborative endeavour between Teesside University, University of Sunderland, Middlesbrough Council and Redcar & Cleveland Council (M&RC).

The focus for this research was to inform the development of the forthcoming integrated service models for service users – one in Middlesbrough and a separate one in Redcar & Cleveland – by meaningfully engaging with current/potential future service users and other stakeholders. This will help ensure that the model meets the diverse range of local needs.

Aim and Objectives of the Project

The overarching aim of the research project is to utilise a co-production approach to explore the needs of service users for a well-being service. This will involve quantitative and qualitative (mixed-methods) data collection methods through online surveys and face-to-face and/or telephone virtual interviews.

Objectives

The objectives of the project are to:

1. Train peers/ambassadors in co-production research methods to be involved in the primary research.
2. Carry out secondary analysis of previously published surveys and reports carried out by Middlesbrough, and Redcar & Cleveland (M&RC) in relation to the research question.
3. Conduct an online survey of individuals and community groups in M&RC to understand the barriers and facilitators in relation to the current services and to inform the new service.
4. Carry out a survey of practitioners and commissioners in M&RC to understand the barriers and facilitators in relation to the current services and to inform their new services.
5. Conduct online interviews with service users and potential service users to more fully explore the findings from the survey and explore needs for the new service.

6. Carry out online interviews with practitioners and commissioners to more fully explore the findings from the survey and explore needs for the new services.
7. Bring together the findings from Objectives 2-6 and make recommendations for the future service.
8. Develop a training module and a manual for service users and practitioners.

Integrated Services

Integrated services provide service users with the opportunity to resolve issues or life-events overall in one place, operating under a 'one-stop-shop' principle (Kunstelj and Vintar, 2004). These services are created based on service users' needs and not from internal requirements or administrative structures in an organisation (Kunstelj and Vintar, 2004). In Europe, 'integrated services' refer to generic healthcare services, with special provisions for homeless individuals, such an enhanced outreach and case identification (Hwang and Burns, 2014). In contrast, dedicated homeless-specific services are much more likely to be provided by non-governmental organisations that are much smaller, have few trained mental health professionals, but are more likely to operate as an active outreach and to work extended hours (Hwang and Burns, 2014). A review of service provision in 14 European cities concluded that homeless-specific services improved access and response to immediate needs, but that generic services with integrated care delivered higher quality mental health care from better trained staff (Canavan et al., 2012). When clients are successfully engaged, generic services might produce better long-term outcomes (Hwang and Burns, 2014).

Anning (2010: 10) argues that "integrated services improve accessibility, speed up referrals and the reduce the stigma attached to services". Indeed, data obtained from the Homeless Link regarding its membership, comprised of frontline homelessness agencies in England, with more than 500 member organisations, noted that services which demonstrated 'good practice' in their ability to work with homeless people with mental health issues possessed the following characteristics: "integrated working protocols; a multi-agency approach; a flexible patient-centred ethos'; accessible at each stage of the client journey" (Savage, 2016: 16). Moreover, having integrated services is contingent on accepting the principle that physical and mental health are not different, but part of the whole picture of an individual's wellbeing (Savage, 2016). Specifically, in relation to mental health, "the provision of fully integrated services to people with mental health needs goes further, into many other aspects of people's lives such as education, work, housing and leisure, and individual lifestyles." (Savage, 2016: 26). Certainly, in terms of housing, studies have identified that standard case management improves housing outcomes, along with housing provision with mental health support being superior to mental health care alone (Hwang & Burns, 2014).

As such, it has been contended that all mental health programmes for homeless individuals should have an integrated approach that accommodates and meets the needs of people with co-occurring mental illness and substance misuse disorders (Hwang and Burns, 2014). Likewise, programmes for homeless individuals should support staff as they seek to overcome challenges in service user engagement, while avoiding the provision of services in a manner that clients believe is "stigmatising, inflexible, or confusing" (Hwang and Burns, 2014: 1543).

For service users with dual diagnosis – the co-existence of substance misuse and mental health problems – service provision should actively engage users and carers from initial assessment through to long-term care (Crome et al., 2009). The saliency of understanding and working with service users' experiences and perspectives cannot be underestimated. A person-centred approach that recognises an individual's unique biography and circumstances will not only enhance the likelihood of a positive relationship between practitioner and client, but should also provide a secure basis upon which to begin to tailor services to particular needs. To do so, there needs to be a shift from a passive model of care to one that perceives service users as active participants in their own recovery that recognises strengths and accepts that recovery may not involve complete abstinence (Crome et al., 2009).

Integration can take place in various ways (Robertson, 2011). For Van Raak et al., (2003: 12), integration must focus on the patient's or service user's perspective, stating that:

> The essence of integrated care is that individuals received the care services they are in need of when and where they need them. It is care which appears seamless to the service recipients and devoid of overlaps or gaps to service commissioner and providers. It is required when the services of separate agencies and individual professionals do not cover all the demands of the multiple-problem service users.

According to Kodner and Spreeuwenberg (2002), a continuum exists from co-operation between entirely separate organisations through the co-ordination of services in multi-disciplinary networks (e.g., managed clinical networks) to fully integrated services with pooled funding, joint planning and management, and multi-disciplinary teams. Services are jointly commissioned and/or funded, delivered by multi-disciplinary teams in which team members are employed by more than one organisation, or delivered by multi-disciplinary teams in which members are employed by the same organisation (Robertson, 2011). Several studies have emphasised the importance of working across divergent teams (see Savage, 2016), with Cook et al., (2017) in qualified agreement with such assertations, stating:

> At the heart of the principle of service integration is the acceptance that no one profession or team can fully meet the demands of citizens. This means that all services cannot meet all the needs of service users in isolation and gaps exist. Recognizing these gaps, how they might be filled and, critically, what service currently in existence is able to meet that need is central to the process of integration. Furthermore, service users' needs are varied and complex and only through integrated working by several services will the best outcomes be achieved (Cook et al., 2017: 11).

According to Miller and McNicholl (2003), there are three degrees of (service) integration: firstly, signposting and coordination: where each service is aware of what others do and is able to signpost them effectively to service users. Plans are aligned and draw on synergies. Secondly, managed processes: services are formally co-ordinated through arrangements, such as integrated assessments and case management. Planning service development also takes place through joint processes. Thirdly, integrated organisations: integrated teams provide services which are commissioned or managed through integrated organisations.

Regarding practical steps to facilitate effective integration of services, research has suggested that there are two key factors needed for integrated care for people with mental health problems: "having the right people in the organisations to drive integration, and;

cross-boundary inter-professional training and education for health and social care professionals" (Savage, 2016: 2**Error! Bookmark not defined.**). For integration to be successful, there are several important factors, including: shared values; co-ordination of services; collaboration between disciplines; and consistent rules and policies at organisational level (Stuart and Weinrich, 2001, Simpson; Miller and Bowers, 2003). In a review of integrated team working, Maslin-Prothero and Bennion (2010) identified a wealth of benefits for both service users and staff. Such advantages included increased job satisfaction; more team working; shared cultures; improved communication; more responsive services; shorter waits between referral and assessment; and better relationships between service users and home care workers. For service users, the effects of (structural integration) include greater attention to prevention, more and acceptable services, as well as empowerment and engagement in decision making (Robinson et al., 2008).

Asthana et al., (2002) explored partnership working in Plymouth health action zones (HAZs). They found that need was the predominant motive, with vast majority of partners agreeing that their organisations had now to work with others to achieve some of their main goals and that other agencies similarly had to work in partnership with them to meet key targets. Of crucial importance, therefore, was the increasing awareness of overlapping agendas, the need to increase co-ordination and reduce duplication of effort and the need to strengthen and develop relationships (Asthana et al., 2002). An associated motive was the importance of being networked, both so that partners could receive relevant information and so that they could keep others informed as to the work they were doing (Asthana et al., 2002). Benefits thus focused on integrated services, information, communication and raised awareness while costs were perceived in terms of time, travel, and speed of decision-making (Asthana et al., 2002).

Due to the adoption of partnership working, one major result has been the progress made in terms of shared principles, knowledge and understanding. In this regard, partners within the HAZ steering group have realised the necessity of partners working together to achieve their goals, with partners stating that they "have learnt more about the aims and

philosophies of the other organisations" (Asthana et al., 2002: 792). This is highlighted by higher levels of trust among partners, as evidenced by the occurrence of frank dialogue around both mutual opportunities and difficulties. In doing so, partners have come to realise that the "identification of the barriers to engagement, involvement, and investment in other agencies [is] the first step towards a solution" and hence the first step towards other more concrete outcomes (Asthana et al., 2002: 792). This is demonstrated by a working culture underpinned by inter-agency synchronisation, which has facilitated integrated drugs services, mental health services, services for people with learning disabilities and integrated planning of services for children and young people.

Crome et al., (2019) point out that it is essential that policy community commissioners, and policy makers are engaged with service provision in a way that ensures they are aware of the multitude of problems that need to be managed without avoiding the challenges that they pose. Research and policy formulation therefore must both recognise and address such challenges. This is paramount when engaging with client groups including those who have dual diagnosis, a group which is often excluded from research that tends to concentrate upon the less complex problems, such as patients with only one substance problem and no associated disorders. On this issue, the involvement of service users with a dual diagnosis on the preparation, organisation, delivery, and evaluation of services is imperative in addressing such oversights. What is more, policies ought to acknowledge the needs of practitioners working with service users in ways that provide a sound basis on which to deliver an integrated and appropriate continuous safe rewarding service (Crome et al., 2009). In doing so, service users are recognised as co-participants or 'coproducer' in shaping services and not solely an end-point user or 'consumer' (Robinson et al., 2008).

Methods and Data

Co-Production

The research project is underpinned by a co-production approach, to ensure that the study will not "research TO people" but will undertake "research WITH people". Utilising a co-production approach ensures that shared learning and collaborative partnership is achieved between all stakeholders involved in the study. Co-production has been described as "sharing information and decision-making between service users and providers which when effectively applied can improve services, and enable service users to become more effective agents of change" (McGeechan et al., 2019: 9; see also Realpe and Wallace, 2010; Penny et al., 2012). Co-production encourages citizens – as service users – to participate as fully as possible at different levels, and according to their needs and capacity. This includes service users contributing to co-production on an individual level, as well as in the design and delivery of services (Holland-Hart et al., 2019; Osborne et al., 2016; Alford, 2014). Through dynamic processes of exchange, synthesis and dissemination, co-production is an increasingly popular research method, employed to unite academics, policy makers and communities to produce research that is not only of academic excellence, also having real public benefit (McGeechan et al., 2019).

Co-production can be integrated into co-commissioning, co-design of pathways, services of research questions, or facilitate working in partnership with third-sector groups, beneficially promoting the involvement of interested groups or indeed, the wider community (Allan et al., 2019). To do so effectively, "true co-production moves beyond … to true partnership working" with the onus on the practitioner to be fully cognisant that all relevant stakeholders are given equal representation, so as not to bias outcomes (Allan et al., 2019: 25). Co-production partnership is valuable as it allows access to expertise that may not be normally available (Allan et al., 2019). This may be in the form of academic analytic or evaluative skills, or expert patient or service user insight into need and how that can best be served (Allan et al., 2019). In addition, the utilisation of a co-production approach allows all partners, especially public health practitioners, to attain supplementary capabilities that may be implemented on subsequent projects, or even in one's everyday life (Allan et al.,

2019). Co-production research can thus provide benefits for numerous stakeholders, including academics, practitioners, policy-makers and the general public, along with delivering better outcomes for those involved (McGeechan et al., 2019). Moreover, co-production research has significant real-world application, and is acquired and applied by those who would most benefit from it to generate positive changes for the lives of individuals, groups and communities (McGeechan et al., 2019; see also Newbury-Birch et al., 2016).

Data Collection

To ensure that the aim and objectives of the study were met, the research team deployed several quantitative and qualitative methods of data collection and analysis, consisting of:

- Secondary analysis of a range of previous survey data collected by M&RC and local survey data of Middlesbrough and Redcar concerning a range of issues (discussed in greater detail in the next section of the report)
- Creation and analysis of online surveys that targeted the different stakeholder groups: the general population and practitioners/commissioners
- Undertaking telephone and/or virtual interviews

The mixed-methods stratagem was utilised in the research project, culminating in a set of studies, delineated in the findings section of this report as ‘Study 1’, ‘Study 2’, and ‘Study 3’. For each study, the research methods used and the findings generated are extensively discussed.

Study 1: Secondary Data Analysis

The first part of the project was a secondary analysis of data collected by M&RC. New insights can be gained by re-analysing the data from new perspectives (Sherif, 2018; see also Fielding, 2000). This is particularly important for the present study in which samples may be difficult to recruit or hard to reach, qualitative secondary analysis can provide insights into sensitive issues, while protecting identities and privacy (Rew et al., 2000).

In this case, pertinent reports and surveys of relevant issues and research, undertaken by M&RC in relation to the project's aim, concerning service usage, domestic abuse and violence, substance misuse, homelessness and supported housing – were read and scrutinised. This literature constituted a large-scale data-set, in which a range of organisations and services were studied and summaries were written-up for each secondary analysis. Therefore, to steer the secondary analysis and sustain focus, two research criteria were developed: *'Clearly Defining an Integrated Service'* and *'Justification for [the] Integrated Service'.* In addition, a further step was executed to identify two yardsticks: *'Similarities'* and *'Differences'* within the chosen research criteria. Concerning the number of organisations and services reviewed, and which rubric they correspond with, this information is provided in the table below. All data outlined in the report has been fully anonymised.

Table 1: Organisations and Services

Organisations and Services	Supported Housing	Homelessness	Domestic Abuse	Substance Misuse	Provision (Range of Services)
Organisation 1	1				
Organisation 2		1			
Organisation 3	1				
Organisation 4					1
Organisation 5		1			
Organisation 6			1		
Organisation 7				1	
Total	**7**				

Findings

Justification for the Set-Up of an Integrated Service

All the organisations included in the secondary analysis had similar views related to their justification for the setting up of an integrated service. Such similarities include the issues with signposting with clients, stakeholders, and commissioners all highlighting inconsistencies in signposting to the appropriate provider due to a lack of clear collaboration between agencies. Issues with partnerships reduce the likelihood of ensuring a person in need arrives at the right provider or local authority. This is particularly acute for service users experiencing homelessness; several stakeholders highlighted issues in accessing services, specifically the lack of signposting and knowing where to go when help is required. T awareness of where to signpost service users, especially people who are vulnerable who need information on numerous issues, including supported housing, by staff in various organisations, will lead to improved partnerships between agencies. By doing so, individuals will be provided with the appropriate avenue for help, coupled with clear referral routes.

A further similarity between the organisations is placing greater emphasis on partnerships within the new, integrated services model. In this regard, the design and set-up of the integrated services model is underpinned by the active encouragement of providers to work together in partnership. This is a positive endeavour, to ensure fewer vulnerable people will not fall through the net, those with complex needs. Such partnerships should include various forms such as pooling budgets and available resources, to ensure that all service users will benefit, regardless of their primary needs. This is along with partnership working and service user involvement. For the former, partnerships via working with partners across numerous agencies is important, to ensure the processes of knowledge sharing and best practices of a skilled and multi-disciplinary team of staff are taking place – fulfilling a vision of the integrated service. In doing so, the various skills and talents of staff across agencies and organisations can be included in a holistic fashion to help service users with numerous needs.

This was highlighted in one local authority's view for homelessness and community support, in which advancing cross-service links coupled with the active involvement of service users, reinforced by genuine co-production, is crucial. In this context, there is a strong need to work with other organisations to aid in the development of partnerships with service users, through organisations such as Expert Link. Expert Link are a peer-led training, policy, and research organisation, with a network of people across the country, who mostly have lived experience of multiple disadvantages, including homelessness, mental health issues, substance misuse, offending, as well as domestic violence and abuse. Expert Link works with their peers to ensure "their voices are heard and listened to, and that they don't become lost or forgotten" (Homeless Link, 2018: 4). As such, Expert Link heavily emphasise co-production working, to empower the lived experiences of service users, including their insight of multiple disadvantages, and that their skills and talents can be drawn on to tackle vulnerability issues. Expert Link work with their peers to advance their aptitudes and confidence, so that they can engage with services, local authorities and systems and co-produce systems, policies, and services (Homeless Link, 2018). In acknowledging the skills and talents of their peers, Expert Link brings together stakeholders to design holistic mode so that agencies are not competing with each other, and there is strong linkage of aspects of "what is important" (Middlesbrough Council Needs Assessment, 2018: 16). This subscribes to a fundamental component of the integrated service via the set-up of "a multi-disciplinary and highly skilled staff team to share knowledge and best practice, which promotes excellence and increases resilience across the network" (Middlesbrough Council Needs Assessment, 2018: 16).

Moreover, collaboration with service users via the development of engagement opportunities and participation in peer reviews will be instrumental in building safe and effective support, to stop service users falling between gaps in provision. Indeed, an intrinsic aim of the integrated service is to engage in authentic co-production and the organic involvement of service users to ensure shared responsibilities, an equal voice, and services that fit the need of those with multiple complex disadvantages. In doing so, the proposed integrated service model will deploy a restorative method, centred on person-centred care. Person-centred care is "a way of thinking and doing things that views the people using

health and social services as equal partners in planning, developing, and monitoring care to make sure it meets their needs" (Health Innovation Network, 2017: 2). This means that people and their families are at the forefront of decision-making and being seen as experts, working alongside professionals to achieve the best outcome. Person-centred care is not focused on providing people with what they want or dispensing information – rather, the desires, values, family situations and lifestyles of people are considered and the person is viewed as an individual who is capable of making decisions on their health and care (Health Innovation Network, 2017). Being compassionate, empathetic, and respectful are essential in working with the individual to develop appropriate solutions. The fundamental philosophy underpinning person-centred care is about "doing things with people, rather than 'to' them" (Health Innovation Network, 2017: 2). Serving as a major justification for the integrated service, interactions between service users, local organisations and the adoption of a co-production approach are all cited as important for meaningful involvement in the system.

A further justification for the integrated service, as highlighted by the various organisations, is the need to support and manage service users with complex needs. Such complex needs include people with chaotic lives and drugs and/or alcohol use issues, women and young people identified in the housing and community support sectors as being vulnerable, having complex needs such as mental health, anti-social-behaviour, crime, substance-misuse, sexual and violent abuse and family relationship breakdowns, which can overlap. One way to support the complex needs of service users is to develop approaches via partnership hubs. For one organisation (5), emerging practices in the Homelessness sector showcase the need to work within "Psychologically Informed Environments" underpinned by effective support planning and trauma-informed care approaches.

By way of explanation, a trauma-informed approach is a "strengths-based way of working with individuals across the lifespan, rooted in a foundational understanding of trauma and the impact that experiencing trauma can have in people's lives" (Hickle, 2020: 1–2). A trauma-informed approach is intended to create opportunities for trauma survivors to regain a sense of control and autonomy in their lives; and involves making every effort to

avoid retraumatising them; working to ensure their environment is physically, emotionally and socially safe; and recognising the impact of traumatic historical, cultural and gendered contexts (Hickle, 2020). This method extends to organisational structure and working practices, whereby professionals working in settings such as social care, mental health, criminal justice and substance misuse, receive trauma-informed supervision and care as they deliver trauma-informed care to others (Hickle, 2020). Due to this organisation's focus on homelessness, approaches via partnership hubs can be beneficial, helping to deliver real prevention to result in good outcomes for those who experience repeat homelessness and for those who have more complex needs. This action underscores another core vision of the proposed integrated service in which there is "a trauma-informed approach embedded throughout the model".

The simplification of pathways has also cited as a justification for the set-up of the integrated service. In this regard, simplifying pathways avoids the risk of people being passed from one agency to the other. Therefore, people with complex needs i.e. an individual with an alcohol dependence and mental health problems will receive support from the outset. This represents a marked departure of traditionally needing to engage with a specific service for an indefinite length of time to receive an unspecified level of support. This is particularly pronounced in the Domestic Abuse sector (Organisation 6), where the main findings of an October 2019 consultation in R&C showed that support for complex needs, coupled with an inclusive, multi-agency approach that is underpinned by a standardised method is key. The requirement of a standardised stratagem, in which referrals are via a single pathway, alongside a central point of access for all domestic abuse support and information, ensures that victims and survivors will not be passed from one place to another. The findings from the consultation assert that doing so will better meet needs, improve experiences, and impact positive outcomes in relation of domestic abuse in the borough.

A further justification for the set-up of the integrated service is the endorsement of a holistic, person-centred approach. This ensures that services will be more easily accessible within a place-based strategy. To elaborate further, place-based strategies "address the

physical, social, structural, and economic conditions of a community that affect the well-being of the children, families and individuals who live there" (National Governor's Association, 2017: 2). Such conditions include poor housing, social isolation, poor or fragmented service provision that leads to gaps or duplication of effort, and limited economic opportunities (Policy Brief, 2011). A place-based approach seeks to address complex problems and to make families and communities more engaged, connected, and resilient (Policy Brief, 2011). In this context, the objective is to enable the service user to access the right service at the right time. To improve the integration of services, a person-centred approach is beneficial for current and potential service users, will help each user to build resilience and have a positive mindset. As current service users and organisations pointed out, a stronger, person-centred approach will directly target the user's individual needs and provide a broad range of support – including social, mental health, and physical support. For one substance misuse service (7) based in Redcar and Cleveland, this tactic is imperative for effective substance misuse prevention.

Finally, strategic co-ordination has also been acknowledged across various organisations to be an important justification for the set-up of the integrated service. In particular, the co-ordination of resources across partners/stakeholders will enable limited resources to be deployed more effectively (within MBC and within partner organisations). Across all commissioning bodies, strong recommendations have been made to introduce collaborative commissioning and integrated systems of care to improve sustainability. In doing so, arrangements can be developed that better suit local circumstances. This is based on national guidance and a strong evidence base around better outcomes for both individuals and providers via working together. Furthermore, a local authority consultation (Organisation 4) on proposed changes to services that support people with needs around homelessness, domestic abuse, sexual violence and abuse across the Borough has recognised that strategic co-ordination can aid in Middlesbrough Council taking a more robust and systematic approach to capturing, collating and analysing data across the whole system. This will provide better understanding of whether the Council has been effective in addressing the needs of individuals and families and if resources have been targeted appropriately.

A caseload management system will enhance how caseloads are managed, as Middlesbrough Council and commissioned services will be able to track individuals, review points of access into a service and measure the impact of the service. As care co-ordination is improved, the risk of duplication is reduced. Within the integrated services model, it is intended that multi-disciplinary working becomes the norm and that 'person centred' risk, support and recovery meetings and plans are developed alongside statutory services such as early help, primary care, criminal justice partners, adult and children's social care. As identified by one organisation, focused on provision encompassing a range of services (Organisation 4), it is intended that a core, physical team that work in co-located settings and specialist services will be created. Doing so will establish a co-ordinated system.

Only one organisation, centred on provision comprised of a range of services (Organisation 4), discussed the issue of duplication across the system in processes, roles and responsibilities and interventions with service users. However, regarding duplication, the justification of the set-up of a new, integrated service was framed in creating a holistic, person-centred approach to support vulnerable people, and the re-design of services that are fit for purpose. In this instance, collaboration between services and partners is vital to reduce duplication and fill gaps in the service(s). In doing so, needs assessments, process mapping and reviews for domestic homicide will be simplified, and the key points of an individual service user's journey will require a single pathway, as opposed to multiple referrals, assessments, and plans.

There were no other differences between the various organisations.

Clearly Defining an Integrated Service

All the organisations included in the secondary analysis possessed several similarities in *clearly defining what an integrated service is*. The importance of robust and co-ordinated pathways between providers is highlighted, working across homelessness, domestic abuse, and substance misuse. Within such pathways, a "no wrong door" model will be deployed,

which will allow people to present at any area of the integrated service, and be assured that they will benefit from the full range of support available to them. Simpler administrative processes are integral to the model, in which user will not be passed between multiple service providers, as has previously been the case (see also report by Middlesbrough Council 2019, for a wider overview).

Irrespective of an individual's "entry point", all service users receive equal opportunity to access support and that their needs are assessed in a timely manner. Along a co-ordinated pathway, service users will be supported with the most appropriate interventions, as well as provision being appropriately matched to need. There will be more effective governance to manage risk as well as formalised arrangements for shared information governance, policies and procedures and workforce development. Specific contracts, such as "Protect and Support" services will be deployed, which will focus on domestic abuse and sexual violence provision (see also report by Middlesbrough Council 2019, for a wider overview). This area will comprise services which offer women's refuge, domestic abuse outreach, domestic abuse counselling, Independent Domestic Violence Advisor (IDVA) and BAME elements (Middlesbrough Council, 2019). Moreover, there will be specialist vulnerable women's accommodation, a women's refuge, and a sanctuary scheme to provide a wide range of support options (Middlesbrough Council, 2019).

The aim of the "Protect and Support" services is to develop an integrated pathway and a single referral point and triage process for all vulnerable women and domestic abuse victims. Likewise, the Teesside-wide BME contract primarily relates to providing domestic abuse support as well as advocacy to women from BME communities who are at risk of or experiencing honour-based violence (HBV), female genital mutilation (FGM) and forced marriage (FM). Emergency help is provided to victims who may need to need to attain a safe place to live, acquire police protection and court ordered protection. To try to strengthen and improve pathways for vulnerable women, the refuge and vulnerable women's' accommodation will now form part of the "Protect and Support" contract. In the Supported Housing sector, it has been identified that for service improvement, particularly for survivors of domestic violence or abuse, more streamlined referral process from social

services and more refuges should be implemented, as well as shorter waiting times for counselling, better promotion of available services.

A further issue from a local authority's supporting housing needs assessment specifically for people with mental ill health, is for the current residential care services to be reviewed in meeting local needs, and for a pathway for rehabilitation to be developed. This measure aligns with another vision of the integrated service model in that a restorative approach will be deployed, where action will involve "doing things with a person, rather than to them or for them". This strategy will enable safe and effective support for those with mental health issues. Similarly, a key recommendation from one provider was to simplify pathways into supported housing, particularly for people with complex needs. The inclusion and development of a Single Assessment Framework which will be underpinned by changing the methods of commissioned services via targeted specifications of co-ordinated support for vulnerable adults, coordinated approach to meeting complex needs - Housing First approach and coordinated domestic abuse provision. This ensures that a wide range of service users are recognised and can receive targeted support via a person-centred approach to combat vulnerability issues.

A further similarity between all organisations pertains to partnerships. In the Supported Housing sector, a 2020 Needs Assessment in R&C recognised that working partnerships are needed to "continue to work with the market, partners and stakeholders to consider how supported housing schemes can contribute to the challenges faced by the R&C Council and other public sector partners for example integrated service delivery with the NHS", to reflect local needs and demands. Moreover, in the Homelessness sector, partnership approaches were cited as necessary, encompassed by actively working in partnership with providers and customers and adopting a co-production strategy to benefit the homeless person and/or service user needing support. Specifically, one partnership tactic identified by the MBC Needs Assessment Team to improve access and referrals was "Alliance Contracting", where there is one contract and one shared objective between multiple organisations and providers, underpinned by a core purpose of "aligned objectives, collective accountability" (Alliance Contracting, 2014: 9). Alliance Contracting is explicitly

referred to as a potential solution to help deliver integrated services in Middlesbrough, as it allows for the sharing of knowledge between and within multi-disciplinary and skilled staff teams. This is hoped to facilitate profound change and better delivery in regard to homelessness in Middlesbrough. Alliance Contracting is gaining traction in other areas such as Stockport, due to its potential to help deliver integrated services, with a 2018 Needs Assessment for Homelessness and community support stating that "there is good evidence that Alliance Contracting will deliver cultural shifts, breaking down organisational barriers".

While Middlesbrough Council has a focus on collaboration, co-ordinating with a range of organisations such as the Domestic Abuse Strategic Partnership which involves a membership of Specialist Support Services, Health and Social Care, Police, Children Services, DTVCRC, Public Health, Mental Health Services, Drug and Alcohol, information-sharing on individuals' needs with local authorities across Teesside is also noted to be an important issue. In doing so, improvements are predicted in partnership working between agencies within Middlesbrough and staff in various organisations will gain awareness of where to signpost vulnerable people and take action to contact the relevant agencies themselves. In addition, a MIND (a mental health charity) report concerning mental health and housing and issues around co-ordination and supporting housing was referred to due to its relevancy:

- The complexity of the interaction between housing and the needs of vulnerable groups requires effective information sharing and collaboration between different agencies and support organisations
- A need for two-way information sharing and networking. Housing management and other organisations staff often lack the knowledge and connections to make appropriate referrals to support providers or supported housing
- A heavy reliance on a small number of formal or informal 'link workers' with established knowledge and contacts. If these networks are well established, they can reduce demand for both health and social care services.

As such, for the provision of supported housing to run effectively and help people,

alternative models of providing supported housing to meet needs more flexibly need to be explored, along with the importance of information sharing between and across agencies and organisations within Middlesbrough.

Integration, in terms of approaches and services, is a further similarity across the organisations. One stakeholder stated that "the key action is to develop a new, integrated model and approach for local residents". Furthermore, the range of issues are also stated for residents "who would benefit from support for issues related to domestic abuse, substance misuse, homelessness and other vulnerabilities". In terms of action to take, R&C refer to there being more prevention and "low level support", ensuring that service users are not given inadequate support and/or disregarded from the service. The new, integrated services model is proposed as it was felt to offer a more integrated approach to wider levels and types of accommodation as it will ensure a strong link between domestic violence and homeless providers and improve accessibility when placement/ move on planning with a victim of domestic abuse. Following a 2019 consultation in Middlesbrough, measures will be taken to improve pathways for vulnerable women. One such strategy is that accommodation for victims of domestic abuse, which will be part of wider vulnerable women's accommodation provision, will now form part of the "Protect and Support'" contract.

For one organisation concerned with provision involving a range of services in Middlesbrough (Organisation 4), the results of a 2019 consultation noted that "integrating the various components under one system will strengthen the service offer, and improve the service user journey from first contact, through support/treatment and onto recovery". Stakeholders felt that these changes would enable a transition from multiple "unconnected" services and contracts to a developed infrastructure which will embed an integrated system. The providers who form part of this system will work in collaboration and be proactive, flexible, and solution-focused in their approach. Integrating the various components under one system will strengthen the service offer, and improve the service user journey from first contact, through support/treatment and onto recovery. This will result in less duplication with referral and assessments, more consistent prevention and support interventions and

reduced or minimal 'signposting' between different parts of the system which often leads to individuals dropping out or disengaging with services. The core offer and management will be responsibility of the council and will be a key part of the infrastructure introducing processes to link and support all parts to work together. This will carry out functions including co-ordination, generating information, and transferring knowledge around the system. The primary purpose of the core offer – named so to reflect the integrated system being "all in one area" – is to provide the "glue" to hold the integrated system together, and "enable all key stakeholder groups to have collective ownership, accountability and responsibility for ensuring the system continually learns and improves over time."

"Making Middlesbrough healthier together – Middlesbrough Joint Health and Wellbeing Strategy 2013 – 2023" mentions *integration* in several areas. These include:

- The integration and partnership working between the NHS, social care, public health, and other local services
- Integrated health and social care services for people with long-term conditions as a priority
- The commissioning and delivery of high-quality, safe, and integrated health and wellbeing services

Redcar and Cleveland Borough Council's previous Health and Wellbeing Strategy focused on three key priorities: a) ensuring children and young people have the best start in life; b) people in R&C having healthier, longer lives; and c) more people leading safe, independent lives. As preventing homelessness supports each of these categories, the Health and Wellbeing Strategy's emphasis "on prevention and integrated services" will be reflected in the new homeless prevention and rough sleeping strategy. At this early stage, the possible headlines emerging for the new strategy are:

- Continue to work to prevent homelessness wherever possible, and to respond effectively to homeless households

- Work with partners to tackle underlying causes of homelessness, including sustainment of tenancies across private and social sectors
- Increase housing options for under 35s, including young people leaving care
- End rough sleeping
- Make best use of resources.

These will be taken forward in the new strategy, supported by a more detailed action plan. For the Homelessness sector, the establishment of a new strategy that encompasses the new, statutory duties introduced in April 2018, under the Homelessness Reduction Act is paramount for integrated services. Central to this new strategy is ensuring that everyone at risk of becoming homeless in the next 56 days is provided with advice and support to prevent or relieve homelessness. A new duty to refer is another core feature, where public authorities refer any clients who might be homeless or threatened with homelessness to the local authority homelessness/housing options team. This covers a broad range of institutions and organisations, such as prisons, probation, social services, and emergency/urgent healthcare. Again, there were no noteworthy differences between the various organisations.

Study 2: Interviews with commissioners, practitioners, and service users

Theme Descriptions

The impact of COVID-19 restrictions on service provision

Commissioners, practitioners, and service users described how the restrictions put in place as a result of the COVID-19 pandemic had impacted on current service provision. Both beneficial aspects and barriers imposed by these restrictions were reported.

One beneficial aspect concerned improved access to services for users. As one commissioner described:

> *We're reaching a demographic of socially isolated people who are maybe moving too much in and using big rural people in that as well, people that struggle to make it into the town centre. And so we're starting to reach people that we haven't before* [PC001].

A decreased need for travel for both staff and service users was also mentioned as a benefit of the remote delivery of services. Furthermore, remote meetings with service users were seen to offer flexibility to clients who had childcare and other commitments. Some commissioners stated that COVID-19 had permanently changed some aspects of service provision for the better, and that these new ways of working would be permanently adopted, alongside more traditional methods of making contact. As this commissioner put it,

> *There's actually some people who are engaging more in that way than in person. So I think we're gonna offer both as a way of delivering group work, we'll do it both ways. Because it appeals more to some than others, or by offering choice* [PC004].

However, a number of barriers to service provision as a result of COVID-19 restrictions were reported as well. These included a lack of access to technology for some service users, and a lack of face-to-face contact, which it was felt that some clients needed. A practitioner stated:

> *I know for lots of people, people struggle with the online stuff, because they don't have the tech, they're not comfortable with the tech, they've got fear of, you know, the internet and social media and those things and all that stuff. So, we've tried to*

support some people to do that as well. And some people just, […] sadly, they're stuck, and they don't want that. They want- they need the face-to-face contact. So, we're trying to support those people as well [PC006].

The majority of the interviewed service users felt that face-to-face contact was preferable to remote forms of contact for addressing their recovery from addiction.

Peer support as the most effective form of support

Both commissioners/practitioners and service users spoke of how being supported by peers was, to them, the most effective way of giving and receiving support. Commissioners detailed how team members had supported each other throughout the pandemic by keeping in touch with each other, and by holding team meetings. As this commissioner described:

We support each other. It's difficult when you're in isolation from home, at the moment, we have a morning flash meeting, we have a check in over teams to see where we're at and anything that needs covering, who's where, who's doing what. […] So we just phone each other, or, or speak, we do have lots of lots of training and opportunities for um complex case studies and things like that [PC003].

Many of the service users interviewed also felt that it was important to them to be supported by peers; within the context of addiction, recovering or recovered individuals were seen to be the most suitable people to offer this support. As one service user put it:

In my opinion, anyone working in that sector should be […] a former addict, it's impossible for a human being to put themselves in that position [US003]. Another service user stated, *I think 80% of their staff is […] people in recovery. So it's peer led. So again, you can relate to them people and there are a lot more* [US001].

In relation to peer support, some service users asserted that they wanted to be treated with respect by staff, and that a non-judgemental attitude of staff helped them feel like equals, accepted, and welcome. This was seen to be more likely when staff were in recovery or had recovered from addiction themselves.

Anticipated benefits of an integrated service to service users

Several benefits of an integrated service were mentioned by both staff and service users. A central anticipated benefit was seen to lie in the provision of holistic care, all in one place. One commissioner stated:

> *I like the idea of it being almost like that one-stop-shop. And everything under one roof to make communication easier, meet the client's needs, that holistic approach* [PC005].

Such holistic care was seen to potentially lead to an improvement in service users' recovery time:

> *If we're all working together, providing that holistic care, then hopefully it will be potentially even a quicker recovery for the client with that wraparound care* [PC005].

Having all services in one place was perceived by staff and both actual and potential service users, to lead to an increase of service users' trust in and familiarity with the service. This continuity of care was viewed as central to a positive experience when using a service, as this would eliminate the need for having to 'tell one's story' multiple times, to various members of staff. For this service user, continuity of care meant:

> *… to build up a rapport or, or, you know, some sort of not a friendship, but, you know, you get to know people. And again, you don't have to go over certain things, because you've already spoke about them* [US001].

Another service user explained:

> *I think that would help so that you're not having to constantly speak to other people. And [currently] even though the other people might have the notes and what not, you still have to repeat and explain some stuff* [US004].

A commissioner suggested that an integrated service could lead to an increase in service users' attendance at appointments by this:

> *If we can reduce that down to its, its, you know, its basic components to make it easier for them. The more likely they are to repeat that. And the more likely they are to attend that appointment* [PC008].

One of the service users suggested that the provision of an integrated service would help provide support until the service user did not require it any longer, and could then discharge

themselves, rather than being discharged by the service prematurely:

> *Just a service that doesn't stop helping a person until they're 'there'* [ie the aim of the service had been achieved]. *That's not available currently. And that's the only thing that gets people better. It's as simple as that* [US003].

An integrated service as a means of improving information-sharing

A particularly important aspect of an integrated service was seen in its potential to improve information sharing, which would increase the efficiency of services and would help break down communication barriers between services. The information-sharing aspect was seen to be closely linked to eliminating the need for clients to keep reiterating their experiences, thereby making for a better experience. As this practitioner stated:

> *I think it can stop repetition implication and stops clients from having to repeat themselves, tell the same story to different people across the system. And so if you can from a client perspective, it's an easier journey and an easier pathway* [PC001].

And as this commissioner put it:

> *I think we've been crying out for it. […] I'm looking forward to it, I think, to be able to have that one port of call type of thing to coordinate, that treatment journey, and actually, hopefully, cut down on a lot of the […] silliness if you like, to make it as seamless as possible for the client, I just think that that journey would be so much better* [PC002].

A commissioner also suggested that an integrated service would help with service users' risk management:

> *If that information, isn't there, we can't case manage people which means, we're not, we can't manage risk, if we're not aware of the risk is there. And also, we can't if we can't access that person. So, for example, a partner agency is aware that that person is changing address and phone number, but don't let us know. Whereas if we were on one system…*[PC003].

Current standard protocols of information sharing as barriers

Although several participants reported that their current systems are efficient, a sub-theme emerged from interviewees' accounts around information sharing: many commissioners and practitioners described how their current standard protocols of information sharing acted as barriers to service provision. These protocols were seen to be inefficient systems, a problem compounded by a lack of staff training in using these systems. As this practitioner explained:

> *I think it's a bit clunky, I think it's messy, and […] I don't think people are supported and trained to use it very well* [PC006].

Sometimes, a lack of consent from service users, with these choosing not to share certain information, could act as a barrier to information sharing too:

> *With GDPR come in […] it's a very fine balance between you know that, I would like to know that person's overall risk. However, I am very much aware that they have to mainly consent to share that information with me* [PC008].

From a service users' perspective, several reported that current service provision came with having to tell one's story several times to different individuals, which they felt to be very stressful. For example, this service user stated:

> *It's hard, especially if it's […] a very emotional problem, you know, that […] you're not having to go to different people and go over it, you know, six or seven times. You know, it's hard. It's hard. I mean, I'm quite an emotional person* [US005].

This seemed to be issue connected to current inefficient information sharing protocols, and/or a lack of information sharing between services, although there may also be other reasons for this (such as lack of time to read case notes between appointments).

Service users' suggested features of an integrated service

Service users and potential service users provided a set of suggestions for what an integrated service should look like. These were separate to the suggestions made by practitioners and commissioners. Actual and potential service users felt that sufficient promotion of the available services was important, for example, via social media or direct

phone calls to potential users. One potential service user felt that people needed to be made aware of what was available:

> *There is a lot going on, you just need to know about them. And I think part of the thing is that people don't know that they're happening* [PotUS002].

Most of the service users who were interviewed remarked that an integrated service should include out-of-hours services - evenings and weekends - which would better accommodate users' needs. For example:

> *I think weekends, personally would be better just because I work full time during the week* [US006]. Another used explained, *a lot of people have a lot of problems sort of on the night. […] A lot of places are nine to five, aren't they, and knowing from experience, you know, sometimes it gets more lonely on a night, you shut the curtains and you're in on your own or whatever, and, and then I sometimes think it would just be nice to know, something […] was there for people that could access well not 24 hours as such, but just out of hours, if there was just somewhere central that, you know, you could just talk to someone really* [US005].

One of the service users also suggested that an integrated service should be located in a safe and easily accessible area, with easily accessible buildings:

> *I struggle with like small rooms or like, difficult to exit and things like that. I like to know that I've got an easy exit* [US004].

Lack of social cohesion in service users' local area

Both service users and potential service users spoke of a lack of community spirit and social cohesion in their local area. As one potential service user put it:

> *I feel like that's sort of missing where you don't know your neighbours, you never interact with them. And you would never do, like, a community event together* [PotUS002].

The causes of this lack of cohesion were attributed to several factors. One was a lack of provision for young people (e.g., community centres), leaving them bored and with nothing to do after school:

> *I think it would be good for the kids to have somewhere to go, because that we always see them grouped you know, on the streets. […] You always feel a bit*

> *intimidated or, like you know, they shouldn't be doing it. So, somewhere for them to go that's maybe a bit more con- I don't know, controlled or where they are looked after better or- that would be better* [PotUS002].

A lack of police presence was mentioned by several interviewees as a further factor contributing to a lack of community spirit, as it was seen to have led to an increase in antisocial behaviour and crime, with high crime rates mentioned as a local problem by most service users. As this user stated:

> *There used to be a police presence, used to be a lot. […] The police were based at the hub, they had, like, a van, they had staff and they used to go round the streets. And at that point, there was next to nobody hanging about, or if there was any more than I think it was five people they were dispersed whereas obviously funding taken away* [US001].

Crime was described as a problem that was passed down over generations within families.

Furthermore, social isolation was claimed to be a problem in service users' local area. This was seen to be partly due to COVID-19 restrictions limiting face-to-face interaction, and partly endemic to the local area. As this user put it:

> *Everyone's online, but not sociable. And I think it's just eroded a lot of society and traditional values. And it just hasn't helped this area with all the other problems it has* [PotUS001].

Study 3: Online Survey

This section summarises the data obtained from the online questionnaires.

Demographics

Following data cleaning, a total of 58 respondents' data was analysed. Of these, 39, just over 67% (67.2%) were located in Middlesbrough with 19 respondents just under 33 % (32.8%) located in Redcar & Cleveland.

The age banding of the 58 respondents showed that the highest number of responses were from the 30-49 years old age group with 34 respondents (58.6%) in that age range. Respondents in the age group 18 – 29 were the next highest group of respondents, 13, just over 22% (22.4%) of the total number of responses. There was one response received from someone aged 66+ (1.7%). Of the 58 respondents 26 (44.8%) were male and 32 (55.2%) female.

In terms of specified ethnicity 53 (91.4%) of the 58 respondents identified as 'White British', 2 (3.4%) identified as 'White other' and 'Asian British', 'Black British', and Mixed/ Multiple ethnic groups each had 1 (1.7%) respondent.

Services

Of the 58 respondents 32, (55.2%) had used at least one/ some/ all of the services subsequently listed. The remainder of the respondents 26, (44.8%) stated they had not used the services subsequently listed in the survey.

Nine service users, (28.1%) of all service users had used Domestic Abuse services. Of these the majority, 5, (55.6%) had used 'My Sisters Place'. Eight service users of the 32 service users, (25%) had used Supported Accommodation services. Five other support services were used by 6 of the 32 service users. Of these MIND was used by 2 people whilst the remaining four individuals had each used differing services.

There were 38 responses indicating how the service was chosen, the majority of respondents, 14 (36.8%) had found out about the service by themselves with 10 (26.3%)

referred by someone else in healthcare/ support service and 6 (15.8%) were referred by a GP.

These responses were mirrored when the respondents were asked how first contact with the service was made. In this case there were 37 responses and of these 15 (40.5%) had found out about it by themselves, with 9, (24.3%) referred by someone else in healthcare/ support services and 6, (16.3%) referred by a GP. These three responses account for 81% of all responses to this question.

When accessing the service for the first appointment/ meeting of the 39 respondents for 23 (59%) this had been 'in person') 10 respondents (25.6%) had used a phone call. Of the 39 respondents only 1 (2.6%) had used video conferencing software (Skype, Zoom etc.)

In terms of preferences for service access1 there were 82 responses of which 32, stated 'in-person' was their preferred means of access, 17 responses would prefer phone calls while 15 responses preferred access via e-mail.

Regarding the best place to access services1 there were 71 responses of which 'the service location' and 'at home/ in your local area' both had 20 responses. At a 'doctors' surgery/ health centre' had 13 responses, while 12 responses were in favour of access being in 'a coffee shop/ café / similar public area' and 6 responses favouring 'council offices/ hub'.

In terms of what works well or what was liked about the service1 following engagement there were 135 responses of which 26 liked the 'Quality of Service'. 24 responses liked the treatment by staff and how easy it was to get in touch and access the service. 21 responses liked 'the staff' and 'the location of the service',16 thought the 'treatment by other service professionals' worked well and there were three other responses.

When asked what was not liked about the service that they had engaged with the following

[1] Multiple responses allowed.

main responses2 were recorded; from the 33 responses recorded 8 responses did not like 'the location of the service', 7 found the 'service difficult to get in touch with' and 'access', 5 disliked their 'treatment by staff' and 4 disliked the 'quality of the service' they received. Three responses were recorded for each of the following reasons, 'staff', 'treatment by other service professionals' and 'other' reasons.

When questioned as to why they had not engaged with services 37 responses were given2. 14 responses indicated that it was not felt that services were needed and 8 responses indicated a lack of awareness of eligibility. Six responses indicated a concern over being labelled or judged while 5 responses indicated a lack of awareness on how to access the services. Finally, 2 responses were recorded for each of the following categories: the services not being located where the respondent needed them and 'other' reasons.

When asked 'what would an Integrated Service look like' there were 102 responses[2]. There were 35 responses for 'everything to be in one place' 31 responses for a 'Tell it Once' approach, 29 responses for 'having the same person to talk to' and 7 responses for 'going to different places, depending on the service being accessed'.

Key Local Issues

When the respondents were asked what they liked about the area where they lived 113 responses[2] were recorded. 28 of responses indicated that their area was 'quiet/ peaceful', 25 that their 'family was/ is close by', 24 that they had 'nice neighbours', 21 that the area was 'safe' and 10 responses indicated they liked their area because of the 'things to do (activities)'. There were 5 'other' responses.

When asked what they did not like about the area in which they lived there were 106 responses[2]. 30 responses indicated 'crime' was an issue, 18 stated they did not like the noise in their area. 16 responses stated that there was 'nothing to do'. Fifteen responses indicated there was a lack of amenities in the area while 11 responses were recorded for each of the categories 'bad neighbours' and that the area was 'unsafe'. 5 responses were

[2] Multiple responses allowed

given for 'other' reasons.

The respondents were then asked what they felt was missing in the area in which they lived. This question generated 77 responses[2]. Thirty-three responses indicated 'community spirit' was missing, 24 responses indicated there was a lack of 'policing (law and order)', 17 responses indicated that 'services' were missing in their area and three responses gave other reasons.

In terms of the main problems people faced in the local area 208 responses were received[2]. Of these 37 responses stated the 'lack of jobs/ low employment' was a main problem. 36 stated 'debt' was a main problem while 35 responses indicated 'drugs'. Crime was identified as a main problem in 29 responses and 'housing' was stated to be a main problem in 22 responses. Physical illness as a main problem in the local area was indicated in 14 responses whilst 2 responses gave other reasons.

Using Services

When asked if they felt they thought people viewed them negatively for accessing services 50 responses were recorded. Of these 20 (40%) indicated this was the case while 30 (60%) stated this was not the case.

Respondents were then asked if they had avoided/ put off using a service they thought they should attend. Fifty responses were received of which 20 (40%) indicated this was the case whilst 30 (60%) indicated they had not avoided/ put off using a service they thought they should attend.

In terms of the reasons why respondent avoided/ put off using a service they thought they should attend a total of 55 responses were given[2]. The greatest recorded numbers of responses, 18 were for 'fear of being judged negatively (friends/ family/ professionals. Nine responses were for 'fear of being seen as "weak" for using a service'. There were 8 responses for 'fear of being seen using the service', 7 responses about 'feelings of embarrassment' and 6 responses for 'fear of not being believed'. Finally, 4 responses were recorded for 'fear of being found out' and 3 responses gave three separate 'other' reasons.

Discussion

This report is an overview of the work conducted as part of the research project, including *achievements* to date, what is currently *in progress*, *next steps,* identified *limitations* and *issues for future consideration*.

Achievements

Partnership working

The application for ethical approval was a key element of the project. To gain ethical approval, all elements of the research project were considered. These consisted of the aim and objectives of the study, participant inclusion and exclusion criteria, recruitment, research methods, including data collection and data analysis, information sharing and data storage; and steps to ensure participant anonymity and confidentiality, alongside discussion of safeguarding.

As such, research materials were utilised for data collection. These consisted of two sets of interview surveys, created using JISC Online Surveys, an encrypted and GDPR-compliant platform. These surveys were both for targeted stakeholder groups in the study: the *general population* of M&RC and *practitioners and commissioners.* Likewise, two sets of tailored interview schedules and discussion guides were also created, tailored for the two stakeholder groups. In keeping with the co-production approach underpinning the research project, all drafts of the online surveys and interview schedules and topic guides were discussed with the internal and external project team, and feedback has been incorporated in the devising and revising of the questions. Indeed, feedback received from various members of the research team has been critical for informing the length of the surveys, the language used, and the inclusion of data from M&RC regarding the list of services to be included. This ensured that the questions included in the surveys and interviews reflected the ethos of the research project and the project's aims and objectives.

Two sets of participant information sheets and consent forms were produced; one set for residents of the local authorities, and the other for other stakeholders. For interviews

conducted online or via telephone, verbal consent was obtained and recorded before the interview took place. Interviews only proceeded once verbal consent was obtained. Ethical approval was granted on 7 October 2020 and data collection commenced.

Data Sharing

As project data was circulated exclusively between these two sites, a Data Sharing Agreement was set up between Teesside University and Middlesbrough Council. The data sharing agreement has been sent over to the external partners at Middlesbrough Council for feedback and approval.

Secondary Analysis

Secondary analysis of research conducted by M&RC linked to the project's aim was completed. Emergent themes concerning the two research criteria were identified, as well as the further two benchmarks: similarities and differences. The secondary analyses have been assessed by other members of the research team, who provided further feedback on the findings. This secondary analysis was been written up as Study 1.

Appointment of practitioner based within MBC to project

A practitioner based at Middlesbrough Council acted as a link between the researchers and the team at M&RC. The link practitioner's proximity to the Middlesbrough Hubs, and given that the university researchers were unable to undertake any face-to-face research due to social distancing because of the COVID-19 pandemic, she distributed hard copies of the surveys to current and potential service users in the hubs and input this data in the online system. The link practitioner also helped recruit, organise and set up the practitioner and commissioner interviews and help with data analysis including 'sense-checking' the usefulness of the recommendations.

Survey data collection took place mostly online, although a small number of printed copies were also submitted. Both sets of surveys for the *general population* and *practitioners and*

commissioners stakeholder groups were disseminated through social media platforms and websites via convenience sampling. The surveys were live for a period of 16 weeks, to endeavour to recruit from a wide cross-section of participants from both groups. The research team also organised interviews with research participants. This was accomplished by contacting those participants who completed the survey and who have agreed to take part in an interview discuss their answers further. Current and potential service users in the hubs were also approached for potential interview.

Limitations

Not all people, especially those deemed as 'vulnerable' possess Internet access or Internet-enabled devices. Similarly, not all people are 'tech-savvy' to engage in virtual interviews and/or other means of online contact. In discussions with the research team, we have tried to mitigate some of these issues, such as through allowing for telephone interviews, or face-to-face interviews in the hubs.

Issues for Future Consideration

Inevitably, while the research project acquired a wide reach in terms of research sample and demographics, some groups are likely to have been under-represented. These include the homeless, and those in controlling households characterised by domestic abuse and/or domestic violence, who have limited freedom and movement, and are unable to contact an appropriate access point. The surveys and interviews were also conducted in English, which means that people who do not have a good standard of English may have been unable to participate.

Recommendations

This project focused on the needs of an underserved and often, in research terms, neglected group of individuals who are often faced with multiple issues. In this co-production partnership, their views were integral to the development of new and co-ordinated services, directed at responding to their needs. Active collaborations with staff responsible for the commissioning and delivery of services were also fostered. Drawing on our analyses, we

outline the following recommendations for the ensuring the effective facilitation of integrated services, in the ways that are resonant with our participants' perspectives:

- More efficient information sharing is a key priority. This was noted to be a central anticipated benefit of an integrated service, leading to a number of further benefits for both service users and commissioners/practitioners.
- The most salient benefit of efficient information sharing between organisations is the elimination of the need to 'tell one's story' multiple times to different members of staff, which is experienced as very stressful by service users.
- More investment should be made in updating/upgrading current information sharing systems, along with staff training to navigate these systems effectively, to improve service provision and delivery.
- Provisions should be made for different types of service delivery, suited to the needs of the service user, especially those who are not tech-savvy and familiar with ICTs.
- COVID-19 has led to changes in the way services are delivered. Some of these are beneficial and will most likely be adopted permanently. However, there are service users who benefit from face-to-face contact and find this preferable to remote service delivery.
- Peer support was highly valued by both staff and service users. Such support should be constantly fostered – via an impartial, respectful, and empathetic approach – in offline and online contexts to maintain staff morale, reduce feelings of social isolation and ensure continuous engagement with services by service users.
- Provisions should be made for alternative access to services, in terms of times and days. Services are not always needed from 9-5, and more flexible provision of services (or access points) would be of great benefit to people needing support out of standard office hours, or over weekends.
- Service users have ideas on what an integrated service should entail that are distinct from those proposed by practitioners and commissioners. The most-often mentioned desired feature of an integrated service was that of out-of-hours access.

- In relation to peer support, some service users asserted that they wanted to be treated with respect by staff, and that a non-judgemental attitude of staff helped them feel like equals, accepted, and welcome. This was seen to be more likely when staff were in recovery or had recovered from addiction themselves.

In summary, there has been a considerable amount of progress in developing an integrated service provision. Challenges remain, particularly in relation to data sharing (from a provider perspective) and out of hours access (from a service user perspective) but what was consistent across all stakeholders was a clear agreement about the need for an integrated service – a 'no wrong door' approach. Further work is needed to best understand how this can be implemented across the LAs, but the identification of key barriers to this, as part of the current work, will hopefully help to guide this debate.

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